STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155344	A. BUILDING 00 B. WING	03/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

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F0000	This visit was for a Recertification and State Licensure Survey. This visit was done in conjunction with the Investigation of Complaint IN00087416. Dates of Survey: March 21, 22, 23, 24, 25, and 28, 2011 Facility Number: 000236 Provider Number: 155344 AIM Number: 100287700 Survey Team: Heather Tuttle, RN. TC. Lara Richards, RN. Janet Adams, RN. Kathleen Vargas, RN. Census Bed Type: 89 SNF/NF 89 Total Census Payer Type: 24 Medicare 56 Medicaid 9 Other 89 Total Stage Two Sample: 40	F0000	Note: This provider wishes this Plan of Corrections to be considered as our credible allegation of compliance. Preparation and /or execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of the Federal and State laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review 4/04/11 by Suzanne Williams, RN			
F0157	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
SS=E	Based on observation, record review and interview, the facility failed to ensure the residents' physician and/or	F0157	157 Resident #3 family and physician were notified of weight loss on 03/30/11. Resident #6 MD and	04/27/2011

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	responsible party were notified following weight changes, blood pressure parameters, episodes of insomnia, refusal of a splint and therapy services and the development of a bruise for 6 of 25 records reviewed for physician and family notification in the sample of 40. (Residents #3, #6, #37, #61, #95, and #144) Findings include: 1. The record for Resident #3 was reviewed on 3/23/11 at 8:40 a.m. Review of the weight sheet indicated on 1/4/11, the resident weighed 163.8 pounds. The resident's weight on 2/1/11 was documented as 150.4 pounds. An entry completed by the Registered Dietitian (RD) on 2/26/11, indicated "February weight 150.4, down 8.1% in 1 month, significant weight loss, physician and family notification was requested." There was no documentation in the Nursing Progress Notes and on the Resident Education sheet to indicate if the resident's family and physician had been notified. Interview with LPN #2 on 3/24/11 at		family were notified on 03/23/11. Resident #37 MD was notified of refusal of therapies on 04/08/11.Resident #61 MD was notified of blood pressures on 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 sleeplessness was addressed by nurse practitioner on 03/16/11. All residents have the potential to be affected by the same deficient practice. The 24 hour report logs were reviewed For the past 30 days to ensure physicians were notified when required. Any issues identified were corrected. The 24 hour report logs will be reviewed by the interdisciplinary team M-F during morning meeting. Physician notification will be verified through chart audits during daily change of condition audits. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11and 04/12/11 by Nursing Administration regarding facility policy/procedures for physician/family notification and changeof condition in residents condition. TheDON/Designee will audit 20% of clinical records requiring physician notification on a weekly basis. Results of these audits will be presented at the monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before	

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	2:00 p.m., indicated that she could not find any physician and family notification based on the RD request on 2/26/11. Interview with the RD on 3/24/11 at 2:10 p.m., indicated after all the monthly weights are reviewed. She lists the ones that require physician and family notification on a separate sheet of paper, not on a recommendation sheet. Interview with the Director of Nursing on 3/25/11 at 10:00 a.m., indicated the resident's physician and family had not been notified of the weight loss for the month of February. **2. The record for Resident #61 was reviewed on 3/23/11 at 2:30 p.m. The resident's diagnoses included, but were not limited to, high blood pressure.** A physician's order dated 1/20/11, indicated the resident's blood pressure was to be checked daily for two weeks. The physician was to be notified if the resident's blood pressure was greater than 160 or less than 110. The January 2011 Medication Administration Record (MAR), indicated the resident's blood pressure was 102/63 on 1/30/11. There was no documentation to indicate if the resident's physician had been notified. The February 2011 MAR, indicated the		discontinuing audits. The Director of Nursing is responsible for ensuring ongoing compliance. Compliance date 04/27/11	

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	resident's blood pressure on 2/2/11 was 107/55. Again, there was no documentation to indicate if the resident's physician had been notified. Interview with Minimum Data Set (MDS) Coordinator #2 on 3/25/11 at 10:20 a.m., indicated there was no documentation related to physician notification of the blood pressures on 1/30 and 2/2/11. Interview with the Director of Nursing on 3/28/11 at 9:45 a.m., indicated the physician was to be notified if the resident's systolic (top number) blood pressure was greater than 160 and less than 110. She further indicated the resident's physician had not been notified of the systolic blood pressure less than 110 on 1/30 and 2/2/11.			
SS=E	3. The record for Resident #37 was reviewed on 3/23/11 at 9:30 a.m. The resident had fractured her right humerus in July 2010. The resident was sent to an orthopedic surgeon for follow up after the fracture. The resident had seen the orthopedic doctor on 8/24/10, and the resident was to have occupational therapy work on range of motion for the right upper extremity, right elbow, and right wrist. The next appointment to the orthopedic doctor was on 9/23/10,and the doctor ordered physical therapy and occupational therapy to the right elbow and hand.		157 Resident #3 family and physician were notified of weight loss on 03/30/11. Resident #6 MD and family were notified on 03/23/11. Resident #37 MD was notified of refusal of therapies on 04/08/11.Resident #61 MD was notified of blood pressures on 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 sleeplessness was addressed by nurse practitioner on 03/16/11. All residents have the potential to be affected by the same deficient practice. The 24 hour report logs were reviewed For the past 30 days to ensure physicians were notified when required. Any issues identified were corrected.	04/27/2011

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	Review of occupational therapy and physical therapy notes for the months of 8/10 and 9/10 indicated the resident had refused therapy and any treatment to her right arm. Review of the clinical record indicated there was no documentation indicating the resident's orthopedic doctor was notified the resident had refused therapies. Interview with LPN #1 on 3/23/11 at 11:10 a.m., indicated there was no documentation indicating the resident's orthopedic physician was notified of the refusal of therapies. 4. The record for Resident #144 was reviewed on 3/23/11 at 1:10 p.m. Nurses' notes indicated the resident had complaints of sleeplessness on 3/8/11 and indicated the Ambien (a hypnotic) he takes at night time only lasts about 3-4 hours. A Physician Notification Fax Form dated 3/8/11 at 7 p.m. was completed on the chart and placed in the physician progress notes. The form was not faxed to the physician. The form had the above information regarding the resident's complaints of sleeplessness.		The 24 hour report logs will be reviewed by the interdisciplinary team M-F during morning meeting. Physician notification will be verified through chart audits during daily change of condition audits. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11and 04/12/11 by Nursing Administration regarding facility policy/procedures for physician/family notification and changeof condition in residents condition. TheDON/Designee will audit 20% of clinical records requiring physician notification on a weekly basis. Results of these audits will be presented at the monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The Director of Nursing is responsible for ensuring ongoing compliance. Compliance date 04/27/11	

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	The Nurse Practitioner had reviewed the form and wrote a new order for Seroquel (an antipsychotic) 25 milligrams (mg) daily. There was no date on the form. Physician orders dated 3/16/11 indicated Seroquel 25 mg daily. Interview with RN #1 on 3/23/11 at 1:50 p.m., indicated she routinely takes care of the resident during the day shift. The RN also indicated the date the nurse practitioner was here and reviewed the resident's complaint was on 3/16/11 (eight days later). Interview on 3/23/11 at 3:30 p.m., with the Director of Nursing, indicated the nurse should have sent the notification to the doctor in a more timely manner.			
SS=E	5. On 3/21/11 at 10:10 a.m., Resident #6 was observed sitting in a wheel chair in her room. There was a bruise to the top of the resident's right hand. The bruise was approximately 3 cm. (centimeters) in diameter. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident's diagnoses included, but were not limited to, osteoarthrosis,		157 Resident #3 family and physician were notified of weight loss on 03/30/11. Resident #6 MD and family were notified on 03/23/11. Resident #37 MD was notified of refusal of therapies on 04/08/11.Resident #61 MD was notified of blood pressures on 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 sleeplessness was addressed by	04/27/2011

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	polymyalgia rheumatica, muscle weakness, and high blood pressure. The 3/11 Physician Order Statement indicated there was an order for the resident to receive two tablets of Aspirin 81 milligrams daily. The 3/11 Nurses' Notes were reviewed. There was no documentation of the physician being notified of the bruise to the right hand. There were no physician notification forms indicating the physician was notified of the bruise. When interviewed on 3/23/11 at 10:25 a.m., LPN #1 indicated she was assigned to care for the resident. The LPN indicated nursing staff were to notify the physician of new bruises and document the notification in the chart When interviewed on 3/23/11 at 2:00 p.m., the Director of Nursing indicated she was not aware of the bruise to the resident's right hand. The Director of Nursing indicated the physician should have been notified of the bruise at the time it was first observed.		nurse practitioner on 03/16/11. All residents have the potential to be affected by the same deficient practice. The 24 hour report logs were reviewed For the past 30 days to ensure physicians were notified when required. Any issues identified were corrected. The 24 hour report logs will be reviewed by the interdisciplinary team M-F during morning meeting. Physician notification will be verified through chart audits during daily change of condition audits. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11and 04/12/11 by Nursing Administration regarding facility policy/procedures for physician/family notification and changeof condition in residents condition. TheDON/Designee will audit 20% of clinical records requiring physician notification on a weekly basis. Results of these audits will be presented at the monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The Director of Nursing is responsible for ensuring ongoing compliance. Compliance date 04/27/11	
SS=E	6. The record for Resident # 95 was reviewed on 3/23/11 at 11:07 a.m. The resident has diagnoses that		157 Resident #3 family and physician were notified of weight loss on 03/30/11. Resident #6 MD and	04/27/2011

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	included, but were not limited to, squamous cell cancer of the neck, valvular heart disease, depression with anxiety, and chronic kidney disease on dialysis. The resident was admitted to the facility on 2/7/11. Review of the resident's weight sheet indicated weights as follows: 2/7/11 220 pounds 2/16/11 230 pounds 2/23/11 235.8 pounds Review of the form titled "Nutritional Progress Notes" indicated an entry dated 2/24/11 written by the Registered Dietician. The entry indicated, "Wt. (weight) 235.8 lbs, up 5.6 lbs. this week and up 15.8 lbs. in past 2 weeks, requested Dr. and family be notified, NAS (No added salt) diet and peritoneal dialysis continues." Review of the Nurse's Notes dated 2/23/11 through 3/16/11 indicated the physician and family were not notified of the resident's weight gain. When interviewed on 3/14/11 at 2:27 p.m., MDS Coordinator #1 indicated the Physician and the resident's family had not been notified of the		family were notified on 03/23/11. Resident #37 MD was notified of refusal of therapies on 04/08/11.Resident #61 MD was notified of blood pressures on 04/08/11.Resident #95 MD was notified of weight gain on 03/05/11.Resident #144 sleeplessness was addressed by nurse practitioner on 03/16/11. All residents have the potential to be affected by the same deficient practice. The 24 hour report logs were reviewed For the past 30 days to ensure physicians were notified when required. Any issues identified were corrected. The 24 hour report logs will be reviewed by the interdisciplinary team M-F during morning meeting. Physician notification will be verified through chart audits during daily change of condition audits. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11and 04/12/11 by Nursing Administration regarding facility policy/procedures for physician/family notification and changeof condition in residents condition. TheDON/Designee will audit 20% of clinical records requiring physician notification on a weekly basis. Results of these audits will be presented at the monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before	

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	weight gain. 3.1-5(a)(3)		discontinuing audits. The Director of Nursing is responsible for ensuring ongoing compliance. Compliance date 04/27/11	
F0170	The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.			
SS=C	Based on interview, the facility failed to ensure mail was being delivered to the residents on Saturday. This had the potential to affect the 89 residents who were residing in the facility. Findings include: Interview with the Resident Council President on 3/23/11 at 1:00 p.m., indicated the residents receive mail Monday through Friday, but they do not receive mail on Saturday. Interview with the Activity Director on 3/24/11 at 3:00 p.m., indicated the mail was delivered by the Activity Department Monday through Friday. She indicated if she was the weekend manager, she will deliver the mail on Saturday, however, it was routinely delivered Monday through Friday. 3.1-3(s)(1)	F0170	F170 Residents are now receiving mail on Saturdays. All residents have the potential to be affected by the same deficient practice. Mail delivery time will be posted on the monthly resident activity calendar for Saturday mail deliveries. Activity Manager will audit mail weekly for delivery to residents. Staff in-serviced on 03/28/11, 0406/11 and 04/12/11 for mail delivery. Results of audit will be presented at monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI committee. Threshold of compliance will be 95% before discontinuing audits. The Activity Manager is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	04/27/2011
F0223	The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.			

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SS=D	The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on record review and interview, the facility failed to ensure each resident was free from verbal abuse related to staff to resident verbal abuse as witnessed by a dietary employee for 1 of 4 allegations of abuse reviewed for 1 of 4 residents reviewed for abuse in the sample of 40. (Resident #B) Findings include: The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at 10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the resident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch." The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician notified and family notified. The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy. Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came	F0223	F223 Resident B has been discharged from facility. The LPN is no longer employed by facility. 2.) All residents have the potential to be affected by the same deficient practice.Allegations of abuse will be reported to Indiana Department of Health and investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. DON/Designee will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** 4.) Allegations of abuse will be reported to Performance Improvement Committee monthly. Tracking and trending will be monitored in Performance Improvement. 5.) The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	04/27/2011

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	back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed." Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had to report to (name) my supervisor." Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter. Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment. Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the			

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	facility. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **3.1-27(b)**			
F0225	The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified			

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	appropriate corrective action must be taken.			
SS=D	Based on record review and interviews, the facility failed to ensure every allegation of abuse was reported immediately to the Administrator and every resident was protected during the investigation for 2 of 4 allegations of abuse reviewed for 2 of 4 residents reviewed for abuse in the sample of 40. (Resident #B and #C) Findings include: 1. Review of the Fax/Incident Report dated 9/19/10 indicated Resident #C stated that visitor (name) sat on the side of her bed to talk to her on Sunday evening. During this time she said he kissed her and patted her stomach area, stating that she took care of herself. (Name) then stated (name) pulled his penis out of his pants exposing his penis to her. The resident stated that the nurse (name) walked in and saw the visitor sitting on the foot of her bed and the nurse (name) asked the visitor to leave the building. A full body assessment was completed for the resident, and there were no noted injuries. Urine was collected, and the urinalysis was positive for a UTI (urinary tract	F0225	F225 Resident B allegations of abuse was investigated. The LPN is no longer employed by the facility. Resident C allegation was investigated. Resident received counseling and psychiatrist services for her well being. Visitor informed he could not enter facility. No actual harm noted to either resident. 2 All residents have the potential to be affected by alleged deficient practice.Allegations of abuse will be reported to Indiana Department of Health and investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. ED/DON will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** Allegations of abuse will be reported to Performance Improvement Committee monthly. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	04/27/2011

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	injection) and an antibiotic was started. Immediate Action taken was both residents were interviewed, family notified, and physician notified. The visitor was asked not to come into the building during the investigation. A police report was made and the police investigation started. Staff was re-inserviced on abuse. An inservice was also given for after hours visitors. Preventative measures taken were the roommates were immediately separated, one to the other side of the building. Staff monitored Resident #C, and referrals were made to senior counseling and a psychiatrist for Resident #C's well being. The documentation indicated they were unable to substantiate allegations, and the police investigation continues. This was the initial and follow up report. Review of witness statements by the CNA who was taking care of Resident #C that night indicated "A man came in to visit (name) (Resident #C's roommate). The man was her son, when he came in he said 'Hi' then he just stood by the door and watched TV and was talking to (name) mother. A few days before this, one of the day			

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	aides told me that (Resident #C) said that one of her roommate's visitors came and tried to kiss her. So when I seen her son come in I kept an eye on them. Nothing happened. When a call light came on, I told the nurse what the CNA had told me and that if he could just keep an eye on them while I went to get the call light. It was just for their safely because I wasn't sure what was going on or even if that was the visitor that was coming on days. When I got back out of the room that I was giving care to, the nurse told me he had to ask the man to leave because he tried to kiss (Resident #C). Again I have not seen anything for myself. So I then went to (Resident #C's) room to check on her and her roommate. They acted fine so I asked (Resident #C) if she needed any help into her night-gown. She said sure but she had already changed into one of her own nightgowns. I began to help her back into bed, then she said, 'That man tried to kiss me.' and I said 'I know that's why the nurse asked him to leave. Did anything else happen?' She then answered 'No'. After making sure she was fine, I began to leave. She then said, 'He tried to rape me.' I asked her what do you mean?' She said 'He tried to kiss me.' So I went out to tell the nurse and he			

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	said 'He just tried to kiss (name) and he seen that so he told him he had to leave.' With me not seeing anything, I told my supervisor what I heard. Then he was the one that seen the action." Review of the witness statement from the RN on duty that evening indicated "The time would have been around 7 p.m. Sunday, September 19, 2010. Sometime during the beginning of my med pass a CNA came up to me and said (Resident #C) said that her roommate's son wants to kiss her. The aide then followed with 'but you know sometimes (Resident #C) gets confused.' I continued to pass a med or two then went to their room. When I entered the room the resident's privacy curtains were wide open and (Resident #C's) roommate introduced her son, but I don't remember his name. (Resident #C) was sitting in her chair by the dresser and this man was standing about 4-5 feet away near the end of the bed with a night gown in his hand facing the resident. It seemed out of place because his mother was already in bed, and he was not facing towards his mother as if to assist her. He was fully clothed, and I did not see his penis exposed. I noticed a strong odor of etoh (alcohol). I told him my name and as precaution and I told him he would			

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have to leave now. He put the nightgown down and left and I don't recall him saying anything to me or his mother on the way out. I looked out the door and saw this guy walking down 100 hall toward main entrance. I helped (Resident #C) with her nightgown and continued my med pass."

Review of another witness statement by the Assistant Director of Nursing at that time, indicated on 9/20/10 indicated Resident #C had reported to her that her roommate's son tried to kiss her last night. She then reported the allegation to the Director of Nursing.

Review of the investigation report indicated the incident was not reported promptly to the Administrator or the Director of Nursing. The Director of Nursing was notified at 3:30 p.m. on 9/20/11.

Interview with the Director of Nursing on 3/25/11 at 12:30 p.m., indicated she was not the Director of Nursing at the time of the incident. She also indicated the Administrator had also left the facility and was employed elsewhere. The Director of Nursing indicated the allegation of abuse was not reported timely to the Administrator or the Director of Nursing nor was the allegation of sexual abuse investigated timely.

2. **The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at**

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	10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the resident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch." The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician notified and family notified. The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy. Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed." Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had			

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	to report to (name) my supervisor." Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter. Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment. Review of all the witness forms and the Physician Notification form indicated they all had the date of 9/29/10 (three days after the allegation had happened and was witnessed). Review of the staffing sheet for 9/26/10 indicated the LPN that had allegedly made those statements to the resident was not immediately removed from the facility and continued to work. Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the facility. The DON indicated the Administrator nor the Director of Nursing at the time, were promptly notified of the allegation of verbal abuse. She further indicated the LPN did not leave the facility immediately and continued to			

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	work the rest of the shift. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **3.1-28(c)** **3.1-28(d)**			
F0226 SS=D	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to follow their Abuse Policy related to promptly reporting and investigating allegations of sexual and verbal abuse and ensuring the residents were protected from further abuse, for 2 of 4 allegations reviewed for abuse for 2 of 4 residents reviewed for abuse in the sample of 40. (Resident #B and #C) Findings include: Review of the current and undated Reporting Alleged Abuse Policy, provided by the Director of Nursing, indicated "All personnel, resident, families, and visitor are encouraged to promptly report incidents of suspected resident abuse and/or neglect to facility administration. All alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin (e.g. bruising and	F0226	F226 Resident B allegation of abuse was investigated and the LPN is no longer employed by the facility. Resident C allegation of abuse was investigated and visitor informed he could not enter facility again. Resident received senior counseling and psychiatric services for her well being. No actual harm noted to either resident. 2. All residents have the potential to be affected by the same deficient practice. Allegations of abuse will be reported to Indiana Department of Health and investigated immediately by ED/Designee. **The facility policy on "Reporting Alleged Abuse" was amended to include "failure to report alleged abuse immediately upon occurrence or allegation will result in corrective action."** 3.) Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on types of abuse, reporting abuse, procedures of and investigation of abuse by Nursing Administration**. Staff will be in-serviced monthly for 3 months and quarterly thereafter on reporting potential abuse immediately to ED/Designee. DON/Designee will audit 24 hour report daily M-F for potential abuse, incidents and accidents and review resident, family and staff complaints. The ED/DON is**	04/27/2011

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	skin tears) will be promptly reported to the administrator and/or director of nursing. The person observing an incident of a resident abuse or suspecting resident abuse will immediate such incidents to their immediate supervisor and/or charge nurse. The supervisor and/or charge nurse will illicit the following information when the incident is reported: the name of the resident, the date and time of the incident, where the incident took place, the names of the persons committing or involved with the incident and the name of any witnesses. If the accused individual is an employee, they will be placed on suspension pending results of the investigation while the incident is being investigated. 1. Review of the Fax/Incident Report dated 9/19/10 indicated Resident #C stated that visitor (name) sat on the side of her bed to talk to her on Sunday evening. During this time she said he kissed her and patted her stomach area, stating that she took care of herself. (Name) then stated (name) pulled his penis out of his pants exposing his penis to her. The resident stated that the nurse (name) walked in and saw the visitor sitting on the foot of her bed and the nurse		**on call 24 hours a day. The weekend on call manager will have her name posted on the staff assignment sheet for immediate notification. All new staff will be informed of abuse policies in orientation and in ongoing education.** Allegations of abuse will be reported to Performance Improvement Committee monthly. The DON is responsible for ensuring ongoing compliance. Compliance date is 04/27/11.	

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	(name) asked the visitor to leave the building. A full body assessment was completed for the resident, and there were no noted injuries. Urine was collected, and the urinalysis was positive for a UTI (urinary tract injection) and an antibiotic was started. Immediate Action taken was both residents were interviewed, family notified, and physician notified. The visitor was asked not to come into the building during the investigation. A police report was made and the police investigation started. Staff was re-inserviced on abuse. An inservice was also given for after hours visitors. Preventative measures taken were the roommates were immediately separated, one to the other side of the building. Staff monitored Resident #C, and referrals were made to senior counseling and a psychiatrist for Resident #C's well being. The documentation indicated they were unable to substantiate allegations, and the police investigation continues. This was the initial and follow up report. Review of witness statements by the			

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	CNA who was taking care of Resident #C that night indicated "A man came in to visit (name) (Resident #C's roommate). The man was her son, when he came in he said 'Hi' then he just stood by the door and watched TV and was talking to (name) mother. A few days before this, one of the day aides told me that (Resident #C) said that one of her roommate's visitors came and tried to kiss her. So when I seen her son come in I kept an eye on them. Nothing happened. When a call light came on, I told the nurse what the CNA had told me and that if he could just keep an eye on them while I went to get the call light. It was just for their safely because I wasn't sure what was going on or even if that was the visitor that was coming on days. When I got back out of the room that I was giving care to, the nurse told me he had to ask the man to leave because he tried to kiss (Resident #C). Again I have not seen anything for myself. So I then went to (Resident #C's) room to check on her and her roommate. They acted fine so I asked (Resident #C) if she needed any help into her night-gown. She said sure but she had already changed into one of her own nightgowns. I began to help her back into bed, then she said, 'That man tried to kiss me.' and I said 'I know			

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	that's why the nurse asked him to leave. Did anything else happen?' She then answered 'No'. After making sure she was fine, I began to leave. She then said, 'He tried to rape me.' I asked her what do you mean?' She said 'He tried to kiss me.' So I went out to tell the nurse and he said 'He just tried to kiss (name) and he seen that so he told him he had to leave.' With me not seeing anything, I told my supervisor what I heard. Then he was the one that seen the action." Review of the witness statement from the RN on duty that evening indicated "The time would have been around 7 p.m. Sunday, September 19, 2010. Sometime during the beginning of my med pass a CNA came up to me and said (Resident #C) said that her roommate's son wants to kiss her. The aide then followed with 'but you know sometimes (Resident #C) gets confused.' I continued to pass a med or two then went to their room. When I entered the room the resident's privacy curtains were wide open and (Resident #C's) roommate introduced her son, but I don't remember his name. (Resident #C) was sitting in her chair by the dresser and this man was standing about 4-5 feet away near the end of the bed with a night gown in his hand facing the resident.			

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	It seemed out of place because his mother was already in bed, and he was not facing towards his mother as if to assist her. He was fully clothed, and I did not see his penis exposed. I noticed a strong odor of etoh (alcohol). I told him my name and as precaution and I told him he would have to leave now. He put the nightgown down and left and I don't recall him saying anything to me or his mother on the way out. I looked out the door and saw this guy walking down 100 hall toward main entrance. I helped (Resident #C) with her nightgown and continued my med pass." Review of another witness statement by the Assistant Director of Nursing at that time, indicated on 9/20/10 indicated Resident #C had reported to her that her roommate's son tried to kiss her last night. She then reported the allegation to the Director of Nursing. **Review of the investigation report indicated the incident was not reported promptly to the Administrator or the Director of Nursing. The Director of Nursing was notified at 3:30 p.m. on 9/20/11.** Interview with the Director of Nursing on 3/25/11 at 12:30 p.m., indicated she was not the Director of Nursing at the time of the			

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	155344	A. BUILDING 00 B. WING	03/28/2011

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	incident. She also indicated the Administrator had also left the facility and was employed elsewhere. The Director of Nursing indicated the allegation of abuse was not reported timely to the Administrator or the Director of Nursing nor was the allegation of sexual abuse investigated timely. 2. **The allegation of verbal abuse for Resident #B was reviewed on 3/25/11 at 10:30 a.m. The incident date was Sunday 9/26/10. The brief description of the incident was the r**esident was in the dining room when a nurse (named), talking in a loud voice, told the resident to eat "because she was not going to lose weight on her watch." The immediate action taken was an investigation was started, Executive Director notified, employee suspended, physician notified and family notified. The preventative measures taken were to have Social Service follow up with the resident and to re-educate staff on the abuse policy. Review of the witness interview form dated 9/29/10 by the dietary employee who witnessed the verbal abuse indicated "I (name) observed a staff member telling a resident that she at least has to eat 50% of her dinner or she couldn't be moved out of dining room or could not go to bed. She also stated she wasn't gonna allow her to lose weight on her watch. Then I left out of the dining room to go back to the kitchen. I came back to clean the dining room. I heard the resident crying (she always does) and the same staff member (name) came into give meds and she asked her to stop crying and if she doesn't, her aide will get mad at her and not put her to bed."			

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Review of another witness interview dated 9/29/10 by the dietary supervisor on duty on Sunday 9/26/10 indicated "Dietary Aide (name) want to ask me a question about if someone could force a resident to eat. She stated that (name) told resident that she had to eat 50% of her food or she would have to sit up in dining room she was not going to be a weight loss on her watch. She told me I had to report to (name) my supervisor."

Review of another witness statement dated 9/30/10 by the a.m. supervisor/cook indicated on Monday 9/27/10 (name) came to me about some abuse she witnessed on Sunday 9/26/10. She told me she had told (name) supervisor/p.m., after she witnessed it. (Name) Dietary Manager was not here and (name) the p.m., supervisor would not be here Monday either. I told her we would not wait for them so we went to (name) the ADON on that Monday and reported everything to her, she took her statements and said she would investigate the matter.

Review of the Suspension Form indicated the LPN was suspended on 9/29/10 three days after the incident. Review of the Termination form indicated on 10/4/10 the employee was terminated from employment.

Review of all the witness forms and the Physician Notification form indicated they all had the date of 9/29/10 (three days after the allegation had happened and was witnessed).

Review of the staffing sheet for 9/26/10 indicated the LPN that had allegedly made those statements to the resident was not immediately removed from the facility and continued to work.

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	Interview with the DON on 3/25/11 at 11:30 a.m., indicated she was not employed at the time of the incident, and the Administrator at that time was no longer employed at the facility. The DON indicated the Administrator nor the Director of Nursing at the time, were promptly notified of the allegation of verbal abuse. She further indicated the LPN did not leave the facility immediately and continued to work the rest of the shift. The DON further indicated the allegation of verbal abuse was substantiated by the facility. **3.1-28(a)**			
F0247 SS=A	A resident has the right to receive notice before the resident's room or roommate in the facility is changed. Based on record review and interview, the facility failed to ensure notice of a room mate change was provided prior to the changing of rooms for 2 of 3 residents who met the criteria for room transfers in the sample of 40. (Residents #42 and #85) Findings include: 1. When interviewed on 3/21/11 at 3:50 p.m., Resident #42 indicated she had had a new room mate change in the last nine months. The resident also indicated she was not given any notice prior to receiving a new room mate.	F0247	F 247 Resident #42 was notified she was receiving a new roommate. Resident # 85 was also notified he was receiving a new roommate. All residents have the potential to be affected by the same deficient practice. All residents are aware of their new roommates. Residents who receive a new roommate will be notified and notification will be documented on the New Roommate Notification Form. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on transfer notifications. All New Roommate Notification Forms will be audited weekly by Social Services for notifications. Results of audit will be presented at monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review by PI Committee. Threshold of compliance will be 95% before discontinuing audits.	04/27/2011

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	The record for resident #42 was reviewed on 3/25/11 at 8:30 a.m. The resident was admitted to the facility on 2/7/11. There was no documentation of the resident being notified of a new room mate in the 2/11 or 3/11 Nurses' Notes or the 2/11 and 3/11 Social Service Progress Notes. **When interviewed on 3/25/11 at 8:59 a.m., Social Service Staff #1 indicated residents were informed by her verbally of a new room mate but she did not document this in the resident's record.** **2. When interviewed on 3/21/11 at 10:27 a.m., Resident #85 indicated he had a new room mate. The resident indicated he was not given notice before receiving the new room mate.** **The record for Resident #85 was reviewed on 3/25/11 at 8:40 a.m. The resident was admitted to the facility 12/3/10 and readmitted on 1/4/11 after being hospitalized. There was no documentation in the 12/10 thru 3/11 Nurses' Notes or the Social Service Progress Notes of the resident being notified of the new room mate.** **When interviewed on 3/25/11 at 8:59 a.m., Social Service Staff #1 indicated residents were informed by her verbally of new room mates but she did not document this in the resident's record.** **3.1-3(v)(2)**		5.) The Social Services Director is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview, the facility failed to ensure social services were provided to maintain each resident's highest practicable well-being related to lack of social service interventions for behaviors for 1 of 3 residents reviewed for psychoacitve medications of the 3 residents who met the criteria for psychoactive medication use in the sample of 40 and social service interventions following resident's statements of depression for 1 of 10 residents who met the criteria for unnecessary medications in the sample of 40. (Residents #6 and #49) Findings include: 1. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident was originally admitted to the facility on 10/15/00. The resident was readmitted to the facility on 6/1/09. The resident's diagnoses included, but were not limited to, diabetes mellitus, polymyalgia rheumatica, and high blood pressure.	F0250	F250 Resident #6 has a Care Plan for depression.Resident #49 a behavior plan was developed. All residents exhibiting inappropriate behaviors have the potential to be affected by the alleged deficient practice. The Social Service Director will complete an audit of residents receiving an antidepressant and ensure they have Care Plans written and those residents who exhibit inappropriate behaviors will have a behavior plan with interventions and behaviors exhibited by resident. Nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on facility policy/procedures for monitoring and documenting resident behaviors and initiating a care plan by Nursing Administration. **To ensure the alleged practice does not recur social services and nursing will review the 24-hour report sheets daily m-f for any behavior issues to ensure behavior/depression care plans are written. Social Service/Designee will also review physician orders daily m-f for new antidepressant/antipsychotic orders. The Social Service Director /Desginee will audit 5 resident behavior logs/physician orders weekly for 4 weeks and then monthly ongoing to ensure care plan and behavior plans are in place.** The results of these audits will be presented at monthly Performance Improvement meeting for 6 months. Plan to be amended as indicated by monthly reviews per the PI Committee.Threshold of compliance will be 95% before discontinuing audits.	04/27/2011

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	Review of the 3/11 Physician Order Statement indicated the resident was currently receiving Wellbutrin (a medication to treat depression) 100 milligrams one tablet by mouth one time daily. A Physician Notification form dated 9/19/10 indicated the physician was notified of the resident complaining of insomnia, very depressed and stated that she would be better off dead. The physician signed and returned the Physician Notification form on 9/19/10 with orders for the above Wellbutrin medication to be initiated. An entry in the 9/10 Nurses' notes made on 9/19/10 at 8:00 p.m. indicated the resident stated that she was depressed, complained of insomnia, stated she slept all day and was unable to sleep at night .The entry also indicated the resident said that she would be better off dead and didn't care if she died. The entry indicated the resident was encouraged and told the physician would be notified of the above. The entry also indicated staff were to continue to monitor the resident. The next entry in the 9/10 Nurses' Notes was made on 9/21/10 at 8:30 p.m. This entry indicated the orders were received and the resident and		The Social Service Director is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	

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	grand daughter were notified. The next entry in the Nurses' Notes was made on 9/22/10 at 10:30 a.m. This entry indicated the resident had a restful night and had no signs or symptoms of distress and staff were awaiting the new order for Wellbutrin which was to be delivered by pharmacy. The entry also indicated the staff were to continue to monitor the resident. Review of the resident's current care plans indicated there were no care plans related to monitoring for signs and symptoms of depression or mood or the use of antidepressant medication. The Resident Mood Interview section on the 12/7/10 MDS assessment indicated the resident was coded as indicating she had symptoms of feeling down, depressed, or hopeless, had trouble falling or staying asleep, or sleeping too much, and feeling tired or having little energy. The CAT worksheet for the MDS indicated the resident triggered for psychotropic drug use and a care plan was to be initiated. When interviewed on 3/24/11 at 1:03 p.m., the Social Service Director indicated she was unaware of the			

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	statement made by the resident on 9/19/10. The Social Service Director indicated the resident had always been upbeat and pleasant and she never observed the resident displaying any signs or symptoms of depression or heard her make any negative statements before. The Social Service Director indicated she should have been informed of the statement made on 9/19/10 and she would have acted upon and followed up with the resident and interventions at that time. The Social Service Director indicated a plan of care for the statements of depression and the start of an antidepressant medication for the resident should have been initiated at that time.			
SS=D	2. The record for Resident #49 was reviewed on 3/23/11 at 9:23 a.m. The resident had diagnoses that included, but were not limited to, dementing illness with associated behavioral symptoms, fracture of left hip and dementia. The Admission MDS (Minimum Data Set) assessment with the reference date of 1/21/11 was reviewed. It indicated the resident understood and understands, the BIMS (Brief Interview for Mental Status) score was 8 indicating moderate cognitive impairment.		F250 Resident #6 has a Care Plan for depression.Resident #49 a behavior plan was developed. All residents exhibiting inappropriate behaviors have the potential to be affected by the alleged deficient practice. The Social Service Director will complete an audit of residents receiving an antidepressant and ensure they have Care Plans written and those residents who exhibit inappropriate behaviors will have a behavior plan with interventions and behaviors exhibited by resident. Nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on facility policy/procedures for monitoring and documenting resident behaviors and initiating a care plan by Nursing Administration. **To ensure the alleged practice does not recur social services and nursing will review the**	04/27/2011

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	The resident was admitted to the facility on 1/14/11 with physician's orders for Zyprexa (an antipsychotic medication) 2.5 mg at bedtime. The "Nurse's Notes" were reviewed. There was an entry dated 2/7/11 at 9:00 p.m. that indicated, ". . . res (resident) conts (continues) to be highly combative, spit meds (medications) out x 2, pinched CNA et (and) struck CNA and nurse when attempting to provide care, res does not redirect . . ." The next entry dated 2/8/11 at 12:50 a.m. indicated, ". . . Writer informed resident of getting VS (vital signs). Resident seemed OK at first, et then became angry at writer. Resident began to swing both hands outward at writer et stated, 'Get the h-- out of here.' Writer was able to get VS after a short period . . ." A physician's order was obtained on 2/8/11. The physician's order indicated the Zyprexa was to be increased to 5 mg at bedtime. The form titled "MDS 3.0 Social Service Progress Note: Resident Interview," dated 2/9/11 and completed by the Social Service Director, was reviewed. The note indicated, "Zyprexa increased to 5 mg		**24-hour report sheets daily m-f for any behavior issues to ensure behavior/depression care plans are written. Social Service/Designee will also review physician orders daily m-f for new antidepressant/antipsychotic orders. The Social Service Director /Desginee will audit 5 resident behavior logs/physician orders weekly for 4 weeks and then monthly ongoing to ensure care plan and behavior plans are in place.** The results of these audits will be presented at monthly Performance Improvement meeting for 6 months. Plan to be amended as indicated by monthly reviews per the PI Committee.Threshold of compliance will be 95% before discontinuing audits. The Social Service Director is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	

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	on 2/8/11 . . . resident had some combative behavior during this reference period - care plan to be written. " The policy titled "Addressing Non-compliant Behaviors" implemented on 8/3/2004 was provided by the Social Service Director on 3/24/11 at 9:45 a.m. She indicated the policy was current. The policy indicated that, "Upon review of referrals and assessing causes of the behavior symptom, a behavior plan will be developed. The behavior plan will specify the problem, behavior symptom, goal, and individualized safe approaches and response interventions." The "Behavior Book" was provided on 3/24/11 by the Social Service Director. There was no behavior plan in the behavior book for Resident #49. Interview with the Social Service Director on 3/24/11 at 9:10 a.m. indicated there was no behavior plan for the resident's combative behavior and resisting care. She indicated the behavior plan was to be documented on the form titled, "Behavior Monitoring Record" and was to be in the "Behavior Book" for the staff to review. The Social Service Director			

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	indicated the behavior monitoring sheet was to be used to identify specific behaviors and to provide interventions to be used by direct care staff to reduce the resident's behaviors. Interview with the Director of Nursing on 3/24/11 at 9:45 a.m. indicated there was no behavior plan for Resident #49. 3.1-34(a)			
F0253 SS=C	The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Based on observation and interview, the facility failed to maintain a clean and comfortable environment related to scratched and marred doors, cabinets and furniture, dirt along the baseboard and floor tile, rust in toilet bowls, and closet doors that would not shut in 4 of 15 resident rooms on the Homeward Bound Unit and the lounge area and shower room, 2 of 9 rooms on the 200 Unit, 2 of 11 rooms on the 300 Unit, 5 of 10 rooms on the 400 unit and in 5 of 14 rooms on the 500 unit. This had the potential to affect 89 residents who resided in the facility. (Rooms 105, 108, 113, 114, 201, 214, 310, 311, 406, 407, 408, 409, 410, 502, 503, 505, 510 and	F0253	F253 On the Homeward Bound Unit: The two-(2) dressers in room 105 have been replaced. The chipped wood door has been fixed. The bathroom door in room 108 has been painted. The chipped and marred door in room 113 has been fixed. The cove base in room 114 has been repaired and bathroom door has been painted. The shower room has been painted underneath the sink. The two (2) table bases have been refinished and the end table removed. On the 200 Unit: Dirt along baseboards of the floor tile in the bathroom of room 214 was cleaned. On the 300 Unit: The wall in room 311 was fixed. Dirt along baseboard of bathroom and scuffmarks were cleaned. Baseboard in room 310 was fixed and metal strip on bathroom floor was removed. Women's shower room discolored grout around toilet was cleaned. Men's shower room discolored grout underneath sink was cleaned. The six cabinet doors under sink in Small Dining Room were refinished. On the	04/27/2011

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	514) Findings include: 1. The following was observed on the Homeward Bound Unit on 3/21 and 3/22/11: a. On 3/22/11 at 8:14 a.m., the bottom four inches of 2 of 2 dressers located in room 105 were scratched and marred. The inside of the room door also had a section of chipped wood that measured 5 inches by 1 inch. Two residents resided in this room. b. The bottom of the bathroom door in room 108 was observed to be scratched and marred in a 12 inch section on 3/22/11 at 8:21 a.m. Two residents resided in this room. c. The door to room 113 was observed to be chipped and marred on the inside in a 3 inch by 1 inch section on 3/22/11 at 8:50 a.m. Two residents resided in this room. d. On 3/21/11 at 2:40 p.m., the cove base was observed to be broken near the bathroom door in room 114. The base of the bathroom door was also scratched and marred. Two residents resided in this room.		400 Unit: The wall in room 406 was fixed. The rust stains were removed from the toilet. The food spillage on floor of room 407 was cleaned. The sticky floor was scrubbed. The rust stains in toilet were removed. The bathroom floor was cleaned of dirt accumulation. Corners by door of resident's room and bathroom have been cleaned. The bathroom floor of room 408 was scrubbed. The rust stains were removed from the toilet. The corners by resident room door and bathroom door have been cleaned. The wall at the foot of bed 2 in room 409 has been fixed. The rust stains were removed from the toilet. The wall in room 410 has been repaired. The dirt has been cleaned in corners of bathroom floor and debris removed. The closet door has been fixed. On the 500Unit: The dirt has been cleaned along baseboard in room 502. The floor in room 503 has been scrubbed and the dirt cleaned along baseboard. The closet doorknob has been tightened. The floor mat in room 505-2 has been replaced. The bathroom floor in room 510 was scrubbed. The bathroom door has been painted. The floor mat in room 514-1 has been replaced. The bathroom floor has been scrubbed. The Environmental Services Director and the Maintenance Director completed an audit of all resident rooms, dining rooms, activity areas, shower rooms and all common areas of the facility to identify concerns related to marred, chipped and scratched doors, walls, furniture and cabinets. An audit was also done to address the adhered dirt in corners and along baseboards, discolored grout in shower rooms, broken cove base, dull and scuffed floors, rust stains in toilet bowels, closet doors and loose knobs, floor mats in the facility. Any area identified as a result of the audit were cleaned, repaired or replaced.	

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	155344	A. BUILDING 00 B. WING	03/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

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	2. The following was observed on the 200 unit on 3/21 and 3/22/11: a. On 3/21/11 at 3:49 p.m., adhered dirt was observed along the base board throughout room 201. One resident resided in this room. b. On 3/22/11 at 8:29 a.m., adhered dirt was observed along the base board of the floor tile in the bathroom of room 214. One resident resided in this room. 3. The following was observed on the 300 unit on 3/21/11: a. At 10:51 a.m., the walls in room 311 were observed to be scratched and marred. An accumulation of dust and dirt was observed along the base board by the bathroom. Scuff marks were also observed along the floor tile. One resident resided in this room. b. At 2:27 p.m., a small section of base board was peeling away from the wall by the closet in room 310. A piece of metal stripping was observed on the bathroom floor. Two residents resided in this room.		The housekeeping and maintenance staff was in-serviced on proper cleaning procedures, repairs and painting on 03/31/11, 04/06/11 and 04/07/11. An environmental audit of every resident room, dining rooms, activity areas, shower rooms and all common areas of the facility will be completed by the Environmental Services Director and the Maintenance Director weekly for 60 days. After the 60 days, audits will be completed for random areas of the facility weekly. The results of the audits will be presented to the Performance Improvement Meetings on a monthly basis for 6 months. Plan to be amended as indicated by monthly review per PI Committee. Threshold of compliance will be 95% before audits are discontinued. The Environmental Services Director and the Maintenance Director will be responsible for ensuring compliance. Date of compliance is 04/27/11.	

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	4. The following was observed on the 400 unit on 3/21 and 3/22/11: a. On 3/22/11 at 8:35 a.m., the walls in room 406 were scratched and marred. Rust stains were also observed in the toilet bowl. Two residents resided in this room. b. On 3/22/11 at 8:37 a.m., there was an accumulation of food spillage on the floor by the garbage can in room 407. The floor was also sticky. Rust stains were observed in the toilet bowl and the bathroom floor had a dull finish and an accumulation of dust and dirt. A large amount of adhered dirt was observed in the corners located by the door to the residents' room and the bathroom door. Two residents resided in this room. c. The bathroom floor in room 408 was observed to be discolored and dirty on 3/22/11 at 8:32 a.m. Rust stains were also observed in the toilet bowl. Adhered dirt was observed in the corners located by the door to the room and the bathroom door. Two residents resided in this room. d. On 3/21/11 at 2:52 p.m., the wall at the foot of bed 2 in room 409 was scratched and marred. Rust stains were also observed in the toilet bowl.			

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	Two residents resided in this room. e. The walls in room 410 were observed to be scratched and marred on 3/21/11 at 2:46 p.m. There was an accumulation of dust and debris on the bathroom floor as well as an accumulation of adhered dirt in the corners of the floor. The closet door would also not shut all of the way. Two residents resided in this room. 5. The following was observed on the 500 unit on 3/22/11: a. Adhered dirt was observed along the base board in room 502 at 9:16 a.m. One resident resided in this room. b. At 9:00 a.m., the tile floor in room 503 had a dull finish. There was also an accumulation of adhered dirt along the base board. The door knob on the closet door was also loose. c. The floor mat located next to bed 2 in room 505 at 9:06 a.m., was observed to be stained in sections and dirty. d. At 8:54 a.m., the bathroom floor in room 510 was observed to have a dull finish. The inside of the bathroom door was observed to be scratched			

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	and marred along the middle. e. The floor mat located next to bed 1 in room 514 at 8:45 a.m., was observed to be stained and dirty. The bathroom floor also had a dull finish and was in need of cleaning. **Interview with the Housekeeping and Maintenance Supervisors on 3/25/11 at 11:30 a.m., indicated the above areas were in need of cleaning and repair.** 6. During the Environmental Tour on 3/25/11 at 10:54 a.m., with the Housekeeping and Maintenance Supervisors, the following was observed: a. The Homeward Bound shower room was observed to have chipped areas of paint underneath the sink. b. The base of 2 dining room tables located in the Homeward Bound lounge/dining area were marred and scratched. The finish on the top of the end table in the lounge area where magazines were placed, was also marred and scratched. c. The grout in the floor tile in the 300 unit Women's shower room was discolored around the toilet. d. The grout in the floor tile located underneath the sink in the Men's shower room on the 300 unit was discolored. e. Six cabinets located under the sink in the Small Dining Room were scratched and marred.			

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	Interview with the Housekeeping and Maintenance Supervisors at the time, indicated the above areas were in need of cleaning and/or repair. 3.1-19(f)			
F0272	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.			
SS=E	Based on observation, record review and interview, the facility failed to	F0272	F272 Resident #3 Quarterly MDS was corrected. **Resident #49** oral	04/27/2011

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	ensure the Minimum Data Set (MDS) comprehensive assessment was coded accurately related to nutrition and weight loss as well as oral cavity status for 5 of 25 residents whose MDS assessments were reviewed in the sample 40. (Residents #3, #49, #95, #102, and #144) Findings include: 1. The record for Resident #3 was reviewed on 3/23/11 at 8:40 a.m. The resident's Quarterly MDS Assessment dated 2/4/11, indicated the resident had not had a weight loss of 5% or more in the last month. The monthly weight sheet indicated the resident weighed 163.8 pounds on 1/4/11 and 150.4 pounds on 2/1/11. The Dietary Progress Note completed by the Registered Dietitian (RD) on 2/26/11, indicated "February weight 150.4, down 8.1% in 1 month, significant weight loss, physician and family notification was requested." Interview with MDS Coordinator #1 on 3/24/11 at 8:20 a.m., indicated she would check on the resident's weight loss to see if the Quarterly MDS was coded accurately. Further interview at		assessment form was updated and significant change completed.**Resident #95 MDS was corrected**.Resident #102 MDS was corrected.Resident #144 MDS was corrected. All residents have the potential to be affected by the same deficient practice. The Dietary Manager will use the most recent weight for reference period when completing MDS. The MDS coordinator will audit residents with significant weight losses for an accurate MDS. **The MDS Coordinator will discuss any discrepancies with Dietary Manager before the completion of the MDS. All oral cavity assessments will be updated by nursing and compared to current MDS to ensure accuracy by the MDS Coordinator.** The significant weight losses will be audited monthly for accurate MDS by DON/Designee. Dietary Manager/Registered Dietician was in-serviced on 04/12/11 on using most recent weight for MDS. Results of audits will be presented at monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/MDS Coordinator is responsible for ensuring ongoing compliance.Compliance date	

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	8:47 a.m., indicated the Quarterly MDS was coded inaccurately related to the resident's weight loss during the assessment reference period. She indicated the Dietary Food Manager completes that section and when she prints up her weights, it was sometimes after the assessment reference period.		04/27/11.	
SS=E	2. The record for Resident #144 was reviewed on 3/23/11 at 1:10 p.m. Review of the initial Minimum Data Set (MDS) assessment dated 2/16/11, with an assessment reference date of 2/10/11 indicated the resident recorded weight was 100 pounds. Weight loss five percent or greater in the past month was not indicated on the assessment. Review of the current weight recorded in the resident's clinical record indicated the resident weighed 100 pounds on 2/3/11 the day he was admitted to the facility. On 2/9/11 another weight was recorded which indicated the resident weighed 92 pounds (an eight pound weight loss in six days). Interview with MDS Coordinator #1 on 3/24/11 at 8:40 a.m., indicated the recorded weight on the MDS should have been the 92 pounds (the weight closest to the assessment reference		F272 Resident #3 Quarterly MDS was corrected. **Resident #49** oral assessment form was updated and significant change completed.**Resident #95 MDS was corrected**.Resident #102 MDS was corrected.Resident #144 MDS was corrected. All residents have the potential to be affected by the same deficient practice. The Dietary Manager will use the most recent weight for reference period when completing MDS. The MDS coordinator will audit residents with significant weight losses for an accurate MDS. **The MDS Coordinator will discuss any discrepancies with Dietary Manager before the completion of the MDS. All oral cavity assessments will be updated by nursing and compared to current MDS to ensure accuracy by the MDS Coordinator.** The significant weight losses will be audited monthly for accurate MDS by DON/Designee. Dietary Manager/Registered Dietician	04/27/2011

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	date), which then would have triggered a weight loss of greater than five percent in the past month. Further interview with MDS Coordinator #1 indicated the resident's weight and weight loss was inaccurately coded. 3. The record for Resident #102 was reviewed on 3/24/11 at 8:30 a.m. The initial MDS dated 2/2/11 with the assessment reference date of 1/29/11 indicated the resident weighed 185 pounds and the resident did not have a weight loss greater than 5 percent in the past month. Review of the resident's weight record indicated the resident weighed 195 pounds on 1/20/11 at the time of admission and then weighed 185 pounds on 1/25/11. The resident had a 10 pound weight loss in five days which is greater than five percent in the past month. Interview with MDS Coordinator #1 on 3/24/11 at 12:25 p.m. indicated the weight recorded on MDS was correct, however, weight loss greater than five percent should have been indicated on the initial MDS.		was in-serviced on 04/12/11 on using most recent weight for MDS. Results of audits will be presented at monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/MDS Coordinator is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	
SS=E	4. The record for Resident # 95 was reviewed on 3/23/11 11:07 a.m. The resident has diagnoses that included,		F272 Resident #3 Quarterly MDS was corrected. **Resident #49** oral	04/27/2011

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	but were not limited to, squamous cell cancer of the neck, valvular heart disease, depression with anxiety, and chronic kidney disease on dialysis. The Admission MDS (Minimum Data Set) assessment with the reference date of 2/14/11 was reviewed. The weight listed on the MDS was 220 pounds. Review of the February 2011 MAR (Medication Administration Record) indicated the resident had daily weights recorded. The resident's weight on 2/14/11 was documented as 199 pounds. Interview with the MDS Coordinator #1 on 3/14/11 at 2:27 p.m. indicated the weight recorded on the MDS was inaccurate. She indicated the weight should have been recorded as 199 pounds and not 220 pounds. 5. Resident #49 was observed on 3/23/11 at 4:45 p.m. in bed. Observation of the resident's oral cavity indicated the resident had no natural teeth on top and had some natural teeth on the bottom. Two of the teeth were noted to be discolored and one tooth was broken The record for Resident #49 was reviewed on 3/3/11 at 9:23 a.m. The resident had diagnoses that included, but were not limited		assessment form was updated and significant change completed.**Resident #95 MDS was corrected**.Resident #102 MDS was corrected.Resident #144 MDS was corrected. All residents have the potential to be affected by the same deficient practice. The Dietary Manager will use the most recent weight for reference period when completing MDS. The MDS coordinator will audit residents with significant weight losses for an accurate MDS. **The MDS Coordinator will discuss any discrepancies with Dietary Manager before the completion of the MDS. All oral cavity assessments will be updated by nursing and compared to current MDS to ensure accuracy by the MDS Coordinator.** The significant weight losses will be audited monthly for accurate MDS by DON/Designee. Dietary Manager/Registered Dietician was in-serviced on 04/12/11 on using most recent weight for MDS. Results of audits will be presented at monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/MDS Coordinator is responsible for ensuring ongoing compliance.Compliance date	

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	to, fracture of left hip, dementing illness with associated behavioral symptoms, pressure ulcer left heel and dementia. The Admission MDS (Minimum Data Set) assessment with the reference date of 1/21/11 was reviewed. The MDS indicated the resident had no oral/dental problems. The form titled "Oral Assessment Form" and dated 1/14/11 did not indicate that the resident had any missing teeth. Interview on 3/23/11 at 4:45 p.m. with the resident's private care giver indicated the resident has no natural teeth on the top, she has an upper denture but she does not like to wear it. She also indicated the resident has a broken teeth on the bottom. Interview with the ADON at 3:45 p.m. on 3/23/11 indicated she was not aware of any oral problems when she completed the MDS. When interviewed on 3/25/11 at 10:11 a.m., MDS Coordinator #1 indicated the Admission MDS and "Oral Assessment Form" dated 1/14/11 were inaccurate. 3.1-31(c)(5) 3.1-31(c)(9)		04/27/11.	
F0279	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are			

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	identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
SS=D	Based on record review and interview, the facility failed to develop a care plan related to statements made by the resident during an resident mood interview conducted by staff during the MDS (Minimum Data Set) assessment reference period of 11/23/10 for 1 of 10 residents reviewed for unnecessary medications in the sample of 40. (Resident #6) Findings include: The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident was originally admitted to the facility on 10/15/00. The resident was readmitted to the facility on 6/1/09. The resident's diagnoses included, but were not limited to, diabetes mellitus, polymyalgia rheumatica, and high blood pressure. Review of the resident's current care	F0279	F279 Resident #6 has a Care Plan for depression. All residents on antidepressants have the potential to be affected by the same deficient practice. An audit of all residents on antidepressants was conducted. Residents on antidepressants will have a Care Plan monitoring for signs/symptoms of depression. Staff in-serviced on 03/28/11, 04/06/11 and 04/12/11 on initiating Care Plans for residents in depression by Nursing Administration. 20% of residents on antidepressants will be audited weekly for antidepressant Care Plans. Results of these audits will be presented in monthly PI Committee for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance is 95% before discontinuing audits. Social Services Director is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	04/27/2011

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	plans indicated there were no care plans related to monitoring for signs and symptoms of depression or mood or the use of antidepressant medication. The Resident Mood Interview section on the 12/7/10 MDS assessment indicated the resident was coded as indicating she had symptoms of feeling depressed, or hopeless, had trouble falling or staying asleep, or sleeping too much, and feeling tired or having little energy. The CAT worksheet for the MDS indicated the resident triggered for psychotropic drug use and a care plan was to be initiated. Review of the 3/11 Physician Order Statement indicated the resident was currently receiving Wellbutrin (a medication to treat depression) 100 milligrams one tablet by mouth one time daily. A Physician Notification form dated 9/19/10 indicated the physician was notified of the resident complaining of insomnia, very depressed and stated that she would be better off dead. The physician signed and returned the Physician Notification form on 9/19/10 with orders for the above Wellbutrin medication to be initiated.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	When interviewed on 3/24/11 at 1:03 p.m. Social Service Director indicated she was unaware of the statement made buy the resident on 9/19/10. The Social Service Director indicated a care plan should have been initiated when the resident made the statements and was started on antidepressant medication. 3.1-35(a)			
F0281 SS=D	The services provided or arranged by the facility must meet professional standards of quality. Based on observation, record review, and interview, the facility failed to provide services to meet professional standards of care related to instructing a resident to rinse her mouth correctly after the administration of an inhaler for 1 of 1 receiving an inhaled medication of the 13 residents who were observed receiving medications by staff. (Resident #150) Findings include: The morning medication administration pass was observed on 3/25/11 at 7:37 a.m. LPN #2 prepared an Advair Diskus inhaler for Resident #150. The Advair Diskus inhaler was in a plastic bag from the	F0281	F281 Resident #150 rinsed her mouth with water. No actual harm noted to resident. All residents on Advair Diskus medication have the potential to be affected by the same deficient practice. All residents on Advair Diskus medication were audited to ensure directions on MAR included "resident to rinse mouth with water and do not swallow". Staff Development Coordinator will audit 20% medication administration process weekly to ensure nurses encourage resident to swish and not swallow water after Advair is given. Licensed staff was in-serviced on proper medication administration of Advair Diskus on 03/28/11, 04/06/11 and 04/12/11. Results of these audits will be presented at the monthly PI	04/27/2011

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	155344	A. BUILDING 00 B. WING	03/28/2011

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	pharmacy. There was a label on the bag that read to rinse the mouth with water after each use and do not swallow the water. The LPN entered the resident's room and primed the inhaler. The LPN instructed the resident to take a puff from the inhaler as she handed the inhaler to the resident. The resident inhaled the medication. LPN #2 then asked the resident if she wanted water and handed the resident a glass of water. The LPN did not instruct the resident to not swallow the water. The resident drank the glass of water and swallowed the water. Information from the ADVAIR.com web site indicated the mouth was to be rinsed with water after breathing in the medication and the user was to spit the water out. The water was not to be swallowed. LPN #2 returned to medication cart following the administration of the inhaler. The LPN reviewed pharmacy instructions on the bag. The LPN indicated the resident should have been instructed not to swallow the water as per the pharmacy instructions on the bag. 3.1-35(g)(1)		Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PICommittee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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F0282	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
SS=D	Based on record review and interview, the facility failed to ensure physician orders were followed related to weekly skin assessments and for ensuring follow up appointments were completed with the doctor for 1 of 2 residents reviewed for pressure ulcers and for 1 of 3 residents reviewed for range of motion of the 7 who met the criteria for range of motion in the sample of 40. (Residents #37 and #58) **Findings include:** **1. The record for Resident #58 was reviewed on 3/28/11 at 9:15 a.m. Review of Physician orders dated 11/4/10 and on the current recap dated 3/11 indicated the resident was to have a skin check by a licensed nurse every week on his shower day-Wednesday.** **Review of the 3/11 Medication Administration Record (MAR) indicated the skin check was only signed out as being completed on 3/9/11. 3/2, 3/16, and 3/23/11 were all blank.** **Review of the Weekly Skin Integrity Data Collection paper indicated the resident's skin was assessed on 3/9/11. The rest of the month of March 2011 was blank.** **Interview with LPN #2 on 3/28/11 at 10:15 a.m., indicated the weekly skin assessments**	F0282	F282 Resident #58 has a weekly skin check. Resident #37 ortho follow up appointments were discontinued. All residents have the potential to be affected by the same deficient practice. All skin checks were audited for completeness. All ortho residents were audited for follow up appointments. Skin checks will be audited weekly by DON/Designee. Residents with new fractures will be audited weekly for follow up appointments. Licensed staff was in-serviced on 03/28/11; 04/06/11 and 04/12/11 on completing skin checks and ensuring follow up appointments are made. Results of the audits will be presented at monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	04/27/2011

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	were to be completed every Wednesday after the resident's shower by the nurse on that unit. The nurse was to complete the MAR as well as the Weekly Skin Integrity Data Collection paper. 2. The record for Resident #37 was reviewed on 3/23/11 at 9:30 a.m. The resident had fractured her right humerus in 7/11. The resident was then sent out of the facility to see an orthopedic physician. The last documented physician visit to the orthopedic's office was on 9/23/10. Review of the 9/23/10 Orthopedic Physician progress notes indicated the resident was to return to the office in two months for a follow up appointment. Review of further physician progress notes for the months of 10/10, 11/10 and 12/10, indicated there was no documentation the resident ever went back to see the orthopedic physician. Interview with LPN #1 3/23/11 at 11:10 a.m., indicated she had called the orthopedic physician office by request, and they verified the last time the resident had been to their office was on 9/23/10. There was no follow up visit completed. 3.1-35(g)(2)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review	F0309	F309 Resident #6 MD and family were	04/27/2011

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	and interview, the facility failed to identify and assess areas of bruising for 2 of 3 residents reviewed for non-pressure related skin conditions of the 3 residents who met the criteria for non-pressure related skin conditions in the sample of 40. (Residents #6 and #132) Findings include: 1. On 3/22/11 at 8:51 a.m., Resident #132 was observed seated in the hallway in her wheelchair. A small area of bruising was observed on the resident's right wrist area. The record for Resident #132 was reviewed on 3/22/11 at 3:00 p.m. The resident's diagnoses included, but was not limited to, extensive skin breakdowns. There was no documentation in the Nursing Progress notes related to a bruise and a Non-pressure Skin Condition Record had not been completed. A physician's order dated 3/16/11 indicated the resident was to receive 81 milligrams (mg) of Ecotrin (a coated Aspirin) daily. The physician's progress note dated 3/16/11, indicated the resident was anemic.		notified of bruise on 03/23/11. Skin check was completed.Resident #132 MD and family were notified of bruise. Skin check was completed on 03/28/11. Documentation of bruise noted in nurse's notes on 03/28/11. All residents have the potential to be affected by the same deficient practice. All skin checks were audited for completeness. Skin checks will be audited weekly by DON/Designee. Licensed staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on completing skin checks weekly. Results of the audits will be presented at monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95 % before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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The Plan of Care dated 11/22/10 and reviewed 2/11, indicated the resident was at risk for skin breakdown related to decreased mobility, bladder incontinence, and receives Ecotrin.

The interventions were as follows:

-Skin check daily with care
-Skin assessed every week per licensed staff
-Monitor ordered labs
-Observe for bruising, blood in stool, bleeding gums.

A Physician's order dated 11/13/10 and listed on the 3/11 Physician's Order Summary (POS), indicated a skin check was to be completed by a Licensed Nurse every week on shower day, which was Monday on the 6-2 shift.

Review of the Weekly Skin Integrity Data collection sheets dated 3/7, 3/14, and 3/21/11, indicated the resident's skin was intact and no bruises were documented.

A skin check by the Licensed Nurse was signed out as completed 3/7, 3/14, and 3/21/11.

On 3/24/11 at 1:34 p.m., the resident

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	was observed in bed. The bruising remained to the resident's right wrist area. Interview with CNA #4 at the time, indicated that she was not aware of any recent falls for the resident and the bruise on the resident's right wrist area was old. She indicated whenever a bruise or skin tear was observed, the Nurse was notified and a Nurse Alert form was completed. Interview with LPN #2 on 3/24/11 at 1:50 p.m., indicated when bruises or skin tears were observed, the CNA's let the Nurse know and a Nurse Alert form was completed. The LPN indicated that she had performed a skin check on the resident that morning and nothing was observed. When shown the resident's right wrist area, the LPN observed the area of bruising. When asked how she got the bruise, the resident indicated she got scared when her tablemate fell the other night and her hand hit the table. The LPN indicated the resident's tablemate fell Sunday evening. When asked if a Nurse Alert form should have been completed, the LPN indicated the CNA's probably did not notice it due to the resident's age spots. An entry was not completed in the			

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	Nursing Progress Notes until 3/28/11 at 9:00 a.m. A Non-pressure Skin Condition Record was initiated on 3/28/11 which indicated the resident had a discoloration to the top of the right wrist. Interview with the Director of Nursing on 3/28/11 at 11:00 a.m., indicated an entry was completed in the Nursing Progress Notes and a Non-Pressure Skin Condition Record was initiated on 3/28/11 rather than on 3/24/11.			
SS=D	**2.** On 3/21/11 at 10:10 a.m., Resident #6 was observed sitting in a wheel chair in her room. There was a bruise to the top of the resident's right hand. The bruise was approximately 3 cm. (centimeters) in diameter. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident's diagnoses included, but were not limited to, osteoarthrosis, polymyalgia rheumatica, muscle weakness, and high blood pressure. The 3/11 Physician Order Statement indicated there was an order for the resident to receive two tablets of aspirin 81 milligrams daily. There was also a physician's order for a skin check to be performed by a licensed nurse every week on the resident's shower day. A care plan initiated on 3/16/10 and last updated with a goal date of 6/11/11 indicated the resident was at risk for skin breakdown as the resident was receiving Aspirin and Prednisone medications daily. Care plan interventions included for weekly skin checks by licensed staff and for staff to observe for		F309 Resident #6 MD and family were notified of bruise on 03/23/11. Skin check was completed.Resident #132 MD and family were notified of bruise. Skin check was completed on 03/28/11. Documentation of bruise noted in nurse's notes on 03/28/11. All residents have the potential to be affected by the same deficient practice. All skin checks were audited for completeness. Skin checks will be audited weekly by DON/Designee. Licensed staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on completing skin checks weekly. Results of the audits will be presented at monthly Performance Improvement Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI	04/27/2011

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	and report bruises. The 3/11 Nurses' Notes were reviewed. There was no documentation of the bruise on the top of the resident's right hand. Weekly Skin Integrity Data Collection sheets for 3/11 were reviewed. The sheets indicated assessments were completed on 3/1/11, 3/8/11, 3/15/11, and 3/22/11. There was a section on the sheets to indicate any bruises that were present. The section to mark bruises was blank on the above four dates. When interviewed on 3/23/11 at 10:25 a.m., LPN #1 indicated she was assigned to care for the resident at this time and on the 3/21/11 day shift. The LPN indicated she thought the bruise on the resident's right hand had been there for awhile. The LPN indicated nursing staff were to notify the physician of new bruises, monitor bruises by charting in the Nurses' Notes and on the weekly skin assessment sheets. LPN #1 indicated the current bruise to the top of the resident's hand was not documented on the weekly skin assessment sheets. When interviewed on 3/23/11 at 2:00 p.m., the Director of Nursing indicated she was not aware of the bruise to the resident's right hand. The Director of Nursing indicated the facility protocol is for staff to document when the bruise is first observed in the Nurses' Notes and to document monitoring and assessment of the bruise in the Nurses' Notes every shift for 72 hours and to notify the physician of the bruise. The Director of Nursing also indicated bruises that are present should be noted on the Weekly Skin sheets completed by licensed nurses also. The Director of Nursing indicated the above was not done for the bruise on the resident's		Committee. Threshold of compliance will be 95 % before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	right hand. **3.1-37(a)**			
F0314	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
SS=D	Based on observation, record review, and interview, the facility failed to ensure residents who currently had pressure ulcers received the appropriate treatments to promote healing related to ensuring weekly skin assessments were completed for a resident who was at risk for pressure ulcers and for completing the correct treatment for a resident with a pressure ulcer for 2 of 2 residents reviewed for pressure ulcers in the sample of 40. (Residents #49 and #58) Findings include: 1. On 3/28/11 at 9:25 a.m. Resident #58 was observed in bed. At that time LPN #3 was providing a treatment to the resident. The resident's left heel was observed with a pressure ulcer. The pressure ulcer	F0314	F314 Resident #58 skin was assessed on 03/28/11, proper treatment applied.Resident #49 now receives the appropriate treatment. All residents have the potential to be affected by the same deficient practice. All residents who are at risk for skin breakage will be assessed. Those with pressure ulcers will have weekly skin checks and correct treatments applied. TAR/Skin check audits will be conducted weekly by DON/Designee. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding weekly skin assessments and completing correct treatments. The DON/Designee will audit the TARS/Skin checks weekly. Results of these audits will be presented at the monthly PI Committee Meeting for 6 months. Plan to be amended as indicated	04/27/2011

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	was noted to have 100 % black eschar. The area was not opened nor was there any drainage noted. The LPN then took a measurement of the left heel pressure ulcer. The area measured 4.7 centimeters (cm) by 5 cm. She then applied granulex to the left heel. The record for Resident #58 was reviewed on 3/28/11 at 9:15 a.m. The resident's diagnoses included, but were not limited to, vascular dementia with psychotic features, muscle weakness, late effect stroke, chronic hepatitis, and frequent falls. Review of nursing progress notes, dated 3/25/11 at 8:00 a.m., indicated the resident had complained of tenderness to the left heel. Physical therapy then assessed the resident's left heel on 3/25/11 at 9:14 a.m., and indicated "discharge patient evaluation and treat order, area to left heel with stable hard eschar and no signs of infection. Communicated with nursing, plan to leave area alone unless there is any indication of infection, unstable, boggy end feel, or regression of skin condition, heels up recommended for pressure relief to area. Will re-evaluate if appropriate." Review of the care plan, dated 8/9/10		per monthly review per PI Committee. Threshold of compliance will be 95 % before discontinuing audits. The DON is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	

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	and updated through 5/11/11, indicated the resident was at risk for skin breakdown related to decreased mobility and bowel and bladder incontinence. The nursing approaches were to assess the skin weekly per licensed staff. **Review of Physician orders, dated 11/4/10 and on the current recap dated 3/11, indicated the resident was to have a skin check by a licensed nurse every week on his shower day-Wednesday .** **Review of the 3/11 Medication Administration Record (MAR) indicated the skin check was only signed out as being completed on 3/9/11. 3/2, 3/16, and 3/23/11 were all blank.** **Review of the Weekly Skin Integrity Data Collection paper indicated the resident's skin was assessed on 3/9/11. The rest of the month of March 2011 was blank.** Review of the Braden scale assessment dated 3/10/10 indicated a score of 14 which was a moderate risk for pressure ulcers. **Interview with LPN#2 on 3/28/11 at 10:15 a.m., indicated the weekly skin assessments were to be completed every Wednesday after the resident's shower by the nurse on that unit. The nurse was to complete the MAR as well as the Weekly Skin Integrity Data Collection paper.**			
SS=D	2. Resident #49 was observed seated in a wheelchair on 3/23/11 at 8:53 a.m. There was a wound vac machine attached to the resident's		F314 Resident #58 skin was assessed on 03/28/11, proper treatment applied.Resident #49 now receives the appropriate	04/27/2011

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	wheelchair. The record for Resident #49 was reviewed on 3/23/11 at 9:23 a.m. The resident had diagnoses that included, but were not limited to, fracture left hip, dementing illness with associated behavioral symptoms, pressure ulcer left heel and dementia. Review of the form titled "Weekly Pressure Sore Tracking Report," dated 3/21/11, indicated the resident had a Stage III (full tissue thickness loss) pressure sore that was 3.8 cm (centimeters) by 3.0 cm by .3 cm in depth. The pressure sore was on the resident's left heel. There was a physician's order dated 3/18/11 for the wound care to the left heel. The physician's order indicated Physical Therapy was to complete the treatment which included sharp debridement with forceps/scissors/scalpel, cleanse with normal saline, apply Santyl ointment, dress with wound vac (negative pressure vacuum) 3 x week Monday, Wednesday and Friday. Nursing staff to do prn (as needed) for soiled or not intact. The wound vac was to be set at 125 mm/hg (millimeters of mercury).		treatment. All residents have the potential to be affected by the same deficient practice. All residents who are at risk for skin breakage will be assessed. Those with pressure ulcers will have weekly skin checks and correct treatments applied. TAR/Skin check audits will be conducted weekly by DON/Designee. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding weekly skin assessments and completing correct treatments. The DON/Designee will audit the TARS/Skin checks weekly. Results of these audits will be presented at the monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95 % before discontinuing audits. The DON is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	

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LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

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	The wound treatment to the resident's left heel was observed on 3/23/11 at 9:45 a.m. The resident was observed in the bed lying on her right side. The Physical Therapist #1 removed the dressing from the resident's left heel. The dressing was attached to the wound vac tubing. The wound and the dressing had no drainage. The Physical Therapist #1 indicated the wound was 1.7 cm by 2.4 cm in size. She indicated the wound was a stage III. There was yellow slough in the center and an area of brown tissue in the very center of the wound, .5 cm in size. The Physical Therapist #1 cleansed the wound with normal saline. She then debrided the wound with a forceps and scissor. The Physical Therapist #1 then applied the dressing and the wound vac tubing. She set the wound vac to 125 mm/hg. She did not apply Santyl ointment to the wound. Interview with Physical Therapist #1 at 10:51 a.m. on 3/23/11 indicated she did not apply Santyl ointment to the resident's wound during the pressure sore treatment. She indicated the physician order dated 3/18/11 did prescribe Santyl ointment to be applied to the wound. She indicated the physician's order written on 3/18/11 was not transcribed to the			

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	TAR (Treatment Administration Record), so she was unaware of the physician's order to use Santyl ointment. Review of the March 2011 TAR at 10:55 a.m. on 3/23/11 indicated the physician's order written on 3/18/11 was not transcribed to the TAR. When interviewed on 3/23/11 at 3:18 p.m. the DoN (Director of Nursing) indicated the physician's order should have been transcribed to the TAR. She also indicated the Physical Therapist #1 should have applied the Santyl ointment as ordered by the physician. 3.1-40(a)(1) 3.1-40(a)(2)			
F0315	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.			
SS=D	Based on observation, record review, and interview, the facility failed to ensure treatment and services were provided to prevent urinary tract	F0315	F315 Resident #137 foley catheter is in a protective bag and suspended off floor. All residents with foley catheter	04/27/2011

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	infections for 1 of 4 residents reviewed for indwelling foley catheters of the 4 residents who met the criteria for foley catheters in the sample of 40. (Resident # 137) Findings include: On 3/21/11 at 2:02 p.m., Resident #137 was observed in bed. The resident had a foley catheter in place. The foley catheter drainage bag was resting on the floor. The drainage bag was not in a protective or dignity bag. The resident was not receiving any care from staff at this time. On 3/22/11 at 8:44 a.m., Resident #137 was observed in bed. The resident had a foley catheter in place. The foley catheter drainage bag was resting on the floor. The drainage bag was not in a protective or dignity bag. The resident was not receiving any care from staff at this time. On 3/23/11 at 2:28 p.m., Resident #137 was observed in bed. The resident had a foley catheter in place. The foley catheter drainage bag was resting on the floor. The drainage bag was not in a protective or dignity bag. The resident was not receiving any care from staff at this time.		have the potential to be affected by the same deficient practice. All residents with foley catheters were audited. No other deficiencies were noted. All foley catheters will be audited daily M-F to ensure they are in protective covers and off the floor by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11by Nursing Administration regarding keeping foley catheter in bag and not on floor. Results of audits will be presented at monthly PI Committee meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	The facility policy titled "Urinary Catheters" was received from the Staff Development Nurse on 3/24/11 at 2:00 p.m. The policy was identified as a current infection control policy. The policy was last revised on 5/21/2004. The policy indicated the foley catheter collection bags were to kept off the floor. When interviewed on 3/24/11 at 11:00 a.m., the Director of Nursing indicated the foley catheter bag should not have been on the floor. 3.1-41(a)(2)			
F0325	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.			
SS=D	Based on record review and interviews, the facility failed to ensure a significant weight loss of five percent in the past month was addressed by the Dietary Food Manager and the Registered Dietitian for 1 of 3 residents reviewed for nutrition of the 13 who met the criteria	F0325	F3251.) Resident #102 weight loss was addressed on 03/17/11 and his Care Plan created on 03/24/11.2.) All residents with weight loss have the potential to be affected by the same deficient practice. The Dietary Manager conducted an audit of residents with weight loss to ensure Dietary Food Manager and Registered	04/27/2011

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	for nutrition in the sample of 40. (Resident #102) **Findings include:** **The record for Resident #102 was reviewed on 3/24/11 at 8:30 a.m. The resident's diagnoses included, but were not limited to,** personal history of fall, abnormality of gait, muscle weakness, coronary artery disease, ataxia, COPD, diabetes, frontal lobe apraxia, aortic stenosis, chronic renal failure, and cancer of prostate. The resident was admitted to the facility from the hospital on 1/20/11. The recorded weight for the resident was 195 pounds at that time. On 1/25/11 the resident's weight was recorded as 185 pounds (a 10 pound weight loss in five days). The next recorded weight was 182 pounds on 2/1/11. The resident was again weighed on 2/9/11 and weighed 165 pounds (a 30 pound weight loss in 20 days). Review of the Nutrition Interview Program dated 1/26/11 indicated the resident was seen because of a 10 pound weight loss in seven days. On 1/27/11 The Registered Dietitian recommended to add 3 ounce med pass 2.0 daily to the resident's diet due to the weight loss. Review of physician orders dated 1/31/11 (four days after the recommendation) indicated med pass 2.0, 4 ounces was added twice a day. Further review of the Nutrition Interview Program reports indicated the resident was seen on 2/2/11 and no recommendations were made, and on 2/10/11 and no		Dietician has addressed them.3.) All residents with significant weight losses will be audited monthly by the Dietary Manager and registered Dietician. Weight losses will be addressed with appropriate interventions. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on addressing significant weight losses with proper interventions.4.) Results of audits will be presented at monthly PI Meeting. Threshold of compliance will be at 95% before discontinuing audits.5.) Dietary Manager is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	recommendations were made. On the 2/10/11 report, the current weight was recorded as 165 pounds and it was noted the resident had lost 17 pounds since the last review. The Registered Dietitian had not written anything on the 2/2 or the 2/10/11 reports. Review of Dietary Progress Notes indicated the next time the Registered Dietitian (RD) reviewed the resident's chart was not until 3/17/11. The RD indicated the resident had lost 6.5% weight in the last month which was a significant weight loss. The RD then recommended to increase the resident's med pass 2.0 4 ounces to three times a day to promote weight gain. There was no care plan initiated for the unplanned weight loss. Review of the current and undated Weight Policy indicated "Any resident who experiences an unplanned weight loss, significant weight change, or undesirable weight change is assessed and monitored by the interdisciplinary team. Each resident with a weight change has a current nutrition assessment/progress note. The Interdisciplinary Care Plan team addresses the root cause of the weight loss/poor intake or weight gain, assesses dining needs if indicated, provides realistic and measurable goals, indicates specific and individualized interventions, and more as needed..." Interview with the RD on 3/24/11 at 3:30 p.m., indicated she was at the facility on 2/4, 2/10, 2/14, 2/17, 2/19, 2/21, 2/24/11. She was also at the facility in March on 3/3, 3/10, 3/17/11, and then on 3/24/11. The RD indicated that she was unaware of the resident's 20 pound			

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	weight loss and she did not make any new recommendations until 3/17/11 when she was given the information the resident lost a significant amount of weight in one month. Interview with the Dietary Food Manager on 3/24/11 at 3:35 p.m., indicated she was aware of the resident's 20 pound weight loss on 2/9/11 since admission and does not know why there were no new recommendations made when he was reviewed in the Nutrition Interview Program. 3.1-46(a)(1)			
F0329	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
SS=D	Based on record review and interview,	F0329	F329 Resident #5 received PRN	04/27/2011

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	the facility failed to ensure 3 of 10 residents who were reviewed for unnecessary drugs in the sample of 40 had their drug regimen free from unnecessary drugs related to monitoring bowel movements and the administration of as needed (prn) laxatives, indication for the use of an anti-psychotic medication and monitoring blood pressure and heart rate prior to giving cardiac medications. (Residents #5, #13 and #144) Findings include: 1. The record for Resident #5 was reviewed on 3/23/11 at 10:30 a.m. The resident's diagnoses included, but was not limited to, constipation. The bowel movement protocol listed on the December 2010, January and February 2011 Medication Administration Records (MAR's), indicated record BM (bowel movement) each shift, give prescribed prn laxative if no BM in 3 days or call MD (physician). A Physician's order dated 2/9/10 and listed on the December 2010, January, February and March 2011 Physician's Order Summaries, indicated the resident was to receive		laxative. No actual harm noted.Resident #13 vital signs are monitored weekly per MD order. Resident #144 antipsychotic was discontinued. All residents have a potential to be affected by the same deficient practice. Audits will be conducted ensuring Rita is checked before giving PRN laxatives, vital signs are taken per physician's order and antipsychotic have appropriate diagnosis. BM, vitals, antipsychotics will be audited weekly by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on checking Rita prior to PRN laxative use, getting vitals per MD order for cardiac meds, and providing proper diagnosis for antipsychotics. Results of audits will be presented at monthly PI Committee meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	Milk of Magnesia Suspension (a laxative) 30 milliliters (ml) once a day as needed. (If no results in 24 hours, call Physician for further orders). The 12/10 MAR, indicated the resident had a bowel movement on 12/13/10 on the 2-10 shift. The "Rita" computer system where the CNA's input their information, indicated the resident did not have a bowel movement on the evening shift on 12/13/10. The resident received the prn Milk of Magnesia on 12/15/10 at 2:00 p.m. The "Rita" system indicated the resident had two large and 1 medium bowel movement on 12/17 and 1 small bowel movement on 12/18/10. The MAR indicated the resident had no bowel movements 12/16-12/18/11 and the prn Milk of Magnesia was given on 12/19/10 at 7:00 a.m. The 1/11 MAR, indicated the resident did not have a bowel movement for all three shifts 1/6-1/10/11. The resident received the prn Milk of Magnesia on 1/9 at 9:00 p.m. and on 1/10/11 at 8:00 a.m. Review of the "Rita" report for month of 1/11, indicated the resident had a medium bowel movement on the evening shift on 1/8/11 and a medium bowel movement on the night shift on			

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	1/10/11. The resident was also documented as having 3 medium bowel movements on 1/11 and 2 medium and 2 small bowel movements on 1/12/11. The 1/11 MAR indicated the resident did not have a bowel movement all three shifts 1/18-1/21/11 and the prn Milk of Magnesia was given on 1/22/11 at 2:00 a.m. The "Rita" report indicated the resident had a small bowel movement on the day shift on 1/21 and a medium bowel movement on the evening shift on 1/21/11. Interview with CNA #5 on 3/24/11 at 3:30 p.m., indicated the resident's bowel movements were documented in "Rita" and the Nurses were also told and they document it as well. She also indicated the Nurses were told if the resident had not gone in 2-3 days. Interview with LPN #2 on 3/25/11 at 10:15 a.m., indicated that she documents on the MAR what the CNAs tell her related to if the resident had a BM or not, and the ADON runs a "Rita" report every 3-4 days to monitor if resident has had a BM and if a prn needs to be given. She further indicated the MAR and Rita reports did not match for the resident and the resident had been given the prn MOM (Milk of Magnesia) when she had had			

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	a BM within the 3 days. Interview with the Director of Nursing on 3/25/11 at 10:00 a.m., indicated there was conflicting information on the MAR and the "Rita" related to bowel movements and the resident did not receive her prn MOM as ordered.			
SS=D	2. The record for Resident #144 was reviewed on 3/23/11 at 1:10 p.m. The resident's diagnoses included, but were not limited to, status post aspiration pneumonia, respiratory failure, hypokalemia, anxiety, GERD, osteoarthritis, leukocytosis, dysphagia, difficulty in walking, muscle weakness, hemiparesis, history of a stroke and ALS. Review of Physician orders dated 3/16/11 Seroquel (an antipsychotic) 25 milligrams (mg) by mouth every night. Review of physician notification form dated 3/8/11 at 7 p.m. indicated "Resident states the Ambien (a hypnotic) he takes helps him fall asleep but he doesn't sleep more than 3-4 straight. He would like to know if he can try 25 mg of Seroquel nightly with the Ambien to help him sleep longer. Needs something for depression related to diagnosis of		F329 Resident #5 received PRN laxative. No actual harm noted.Resident #13 vital signs are monitored weekly per MD order. Resident #144 antipsychotic was discontinued. All residents have a potential to be affected by the same deficient practice. Audits will be conducted ensuring Rita is checked before giving PRN laxatives, vital signs are taken per physician's order and antipsychotic have appropriate diagnosis. BM, vitals, antipsychotics will be audited weekly by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on checking Rita prior to PRN laxative use, getting vitals per MD order for cardiac meds, and providing proper diagnosis for antipsychotics. Results of audits will be presented at monthly PI Committee meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before	04/27/2011

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	ALS. The Nurse Practitioner reviewed the fax form on 3/16/11 and wrote the order for the Seroquel; however, there was no diagnosis for the indication for its use. Interview with RN#1 on 3/23/11 at 1:50 p.m. indicated there was no diagnosis for the Seroquel. Further interview with RN #1 indicated another nurse had suggested to the resident that he try Seroquel for sleep.		discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	
SS=D	3. The record for Resident #13 was reviewed on 3/24/11 at 11:53 a.m. The resident's diagnoses included, but were not limited to, hemiplegia (weakness of the extremities), senile dementia, convulsions, and depressive disorder. Review of the 3/11 Physician Order Statement indicated there was an order for the resident to receive Metoporol 25 milligrams one tablet daily. The order also indicated the Metoporol was to held if the resident's heart rate was less the 55 or the systolic (upper number) BP (blood pressure) was less the 100. The 3/11 Medication Administration Record indicated the resident		F329 Resident #5 received PRN laxative. No actual harm noted.Resident #13 vital signs are monitored weekly per MD order. Resident #144 antipsychotic was discontinued. All residents have a potential to be affected by the same deficient practice. Audits will be conducted ensuring Rita is checked before giving PRN laxatives, vital signs are taken per physician's order and antipsychotic have appropriate diagnosis. BM, vitals, antipsychotics will be audited weekly by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on checking Rita prior to PRN laxative use, getting vitals per MD order for cardiac meds, and providing proper diagnosis for antipsychotics.	04/27/2011

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	received the Metoporol 25 milligrams daily at 8:00 a.m. 3/1/11 through 3/24/11. The resident's heart rate was not recorded on any of the above dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 3/3/11, 3/7/11, 3/14/11, 3/17/11, and 3/21/11. The 2/11 Medication Administration Record indicated the resident received the Metoporol 25 milligrams daily at 8:00 a.m. 2/1/11 though 2/28/11. The resident's heart rate was not recorded on any of the above dates. The only dates the resident's blood pressure reading was recorded on the 6:00 a.m. to 2:00 p.m. shifts were on 2/3/11, 2/7/11, 2/10/11, 2/24/11, and 2/28/11. When interviewed on 3/24/11 at 3:20 p.m., the Director of Nursing indicated the resident's heart rate and blood pressure should have been taken prior to the administration of the medication as ordered by the physician. 3.1-48(a)(3) 3.1-48(a)(4)		Results of audits will be presented at monthly PI Committee meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	
F0333	The facility must ensure that residents are free of any significant medication errors.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D	Based on record review and interview, the facility failed to ensure residents were remained free of significant medication errors related to the administration of insulin as ordered for the physician for 1 of 10 residents reviewed for unnecessary medications in the sample of 40. (Resident #85) Findings include: The record for Resident #85 was reviewed on 3/22/11 at 3:11 p.m. The resident was first admitted to the facility on 12/31/10. The resident was sent to the hospital on 1/2/11 and was readmitted to the facility on 1/4/11. The resident's diagnoses included, but were not limited to, diabetes mellitus and acute pancreatitis. Review of the 1/4/11 re admission physician orders indicated there was an order for staff to complete accu checks (test to check blood glucose level) before meals and night prior to going to sleep. There was also a physician's order for the resident to receive Novolin insulin coverage per a sliding scale. The order for the sliding scale insulin coverage was as follows: Blood glucose 1-149 - 0 units to be given Blood glucose 150-199 - 1 units of	F0333	F333 Resident #85 insulin order was clarified on 01/24/11. 2 .) All residents have the potential to be affected by the same deficient practices. All diabetic residents who are at risk for medication errors will have appropriate sliding scale orders.3.) Diabetic sliding scale audits will be conducted weekly by DON/Designee. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding getting proper sliding scale orders and calling physician for blood sugars out of parameters.4.) Results of these audits will be presented at the monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits.5.) The DON is responsible for ensuring ongoing compliance.Compliance date 04/27/11.	04/27/2011

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	155344	A. BUILDING 00 B. WING	03/28/2011

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	Novolin R insulin to be given Blood glucose 200-249 - 3 units of Novolin R insulin to be given Blood glucose 250-299 - 5 units of Novolin R insulin to be given Call the physician for blood glucose level above 300. A physician's order was written on 1/11/11 to not call the physician unless the blood glucose level was greater than 400. There were no orders written to change the sliding scale insulin coverage at this time. A physician's order was written on 1/24/11 to change the sliding scale insulin coverage as follows: Accu checks before meals and at night with sliding scale coverage with Novolin R insulin: Blood glucose 1-149 - 0 units to be given Blood glucose 150-199 - 1 units of Novolin R insulin to be given Blood glucose 200-249 - 3 units of Novolin R insulin to be given Blood glucose 250-299 - 5 units of Novolin R insulin to be given Blood glucose 300 and greater - 10 units of Novolin R insulin to be given. Notify physician of blood glucose level of 400 or greater. The January 2011 Glucometer Flow			

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	record was reviewed. The following blood glucose levels were recorded: 1/20/11 at lunch: 353 1/21/11 at lunch: 319 1/22/11 at lunch: 307 The 1/11 Medication Administration Record indicated the resident received 5 units of Novolin R insulin at 11:00 a.m. on 1/20/11, 1/21/11, and 1/22/11. The physician's order for these dates indicated the ordered sliding scale only was to cover blood glucose levels up to 299. When interviewed on 3/25/11 at 11:00 a.m., the Director of Nursing indicated there was no physician's order for the amount of coverage to be administered for blood glucose levels above 299 from 1/11/11 through 1/24/11. 3.1-48(c)(2)			
F0431	The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently			

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	accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.			
SS=E	Based on observation, record review, and interview, the facility failed to ensure multi dose vials of insulins and tuberculin were not stored past the recommended dates for medications on two medication carts and 1 of 2 medication rooms. This had the potential to affect 69 residents who resided on the 200, 300, 400, and 500 units and for 20 residents who resided on the 100 unit.(Residents #68 and #8) (The 100 hall Medication cart) (The 200/300/400/500 hall Medication room) (The 500 hall Medication cart)	F0431	F431 Residents #68 and #8 insulin was discarded and new insulin received.The TB solution was also discarded. All residents have the potential to be affected by the same deficient practice. All expired TB and insulin vials were discarded. Insulin/TB vials will be audited weekly for expiration dates. Licensed nursing staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding disposing of TB/Insulin vials after 28 days. Results of these audits will be presented at the monthly PI Committee Meeting for 6 months.	04/27/2011

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	Findings include: The facility pharmacy policy titled "Insulin Storage Recommendations" was reviewed on 3/25/11 at 2:00 p.m. The Director of Nursing provided the policy and indicated the policy was current. The policy had a revised date of September 23, 2010. The policy indicated unopened vials of Novolin insulin could be stored at room temperature for 28 days. The policy indicated opened vials of Novolin insulin could be stored at room temperature for 28 days. 1. Storage of medications in the 100 hall medication cart was observed on 3/25/11 at 10:37 a.m. with RN #2. A opened vial of Novolin R insulin was observed in the cart. The label on the insulin vial indicated the insulin was ordered to be used for Resident #68. The "date opened" label on the vial of insulin indicated it was first opened on 2/20/11. When interviewed on 3/25/11 at 10:37 a.m., RN #2 indicated opened vials of insulins were to be discarded thirty days after they were first opened. 2. Storage of medications in the 500 hall medication cart was observed on 3/25/11 at 11:00 a.m. with the Staff		Plan to be amended as indicated per monthly review per PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/SDC are responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	Development Nurse. There was an unopened vial of Novolin R insulin stored in the cart. The label on the vial of insulin indicated the insulin was ordered to be used for Resident #8. The vial of Novolin insulin was delivered on 1/24/11. 3. The medication room on the west wing for the 200/300/400/500 halls was checked on 3/25/11 at 10:54 a.m. with the Staff Development Nurse. There was an opened vial of Tuberculin Purified Protein Derivative in the refrigerator in the medication room. The label affixed to the box indicated the Tuberculin was first opened on 2/20/11. The manufacturer information insert indicated the vials were to be discarded 30 days after opening. When interviewed on 3/25/11 at 12:24 p.m., the Director of Nursing indicated the opened and unopened vials of insulin should have been stored for only 28 days as per the pharmacy policy. The Director of Nursing also indicated the opened vial of Tuberculin was only to stored for 30 days as per the manufacturer instructions. **3.1-25(k)(6)**			

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F0514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
SS=D	Based on observation, record review, and interviews, the facility failed to ensure follow up documentation and assessment was completed related to a cast/splint application and completing accurate joint mobility assessment for 2 of 25 residents reviewed for complete and accurate records in the sample of 40. (Residents #6 and #37) Findings include: 1. The record for Resident #37 was reviewed on 3/23/11 at 9:30 a.m. The resident had fallen out of bed on 7/20/10 and was sent to the hospital for complaints of pain and for an X-ray. The resident returned on that day with a cast to her right arm and to see an orthopedic physician. The resident went to the orthopedic appointment on 7/27/10 and returned	F0514	F514 Resident #6 joint mobility assessment was corrected on 03/29/11.Resident #37 no longer requires splints, or slings due to residents refusals. All ortho residents have the potential to be affected by the same deficient practice. All joint mobility assessments will be updated. All residents with splints/casts were audited for placement. Joint mobility assessments will be accurately completed weekly. Splint application will be audited daily M-F by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding accurate joint mobility assessments and follow up documentation with fractures. Results of these audits will be presented at monthly PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/Designee is	04/27/2011

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	on that day. There was no documentation the resident returned with the cast to the right arm. Review of the orthopedic physician's progress note dated 7/27/10 indicated "fell on elbow, complaints of right elbow pain, place in splint." Follow up in two weeks. Review of Nursing Progress Notes dated 7/27/10 indicated there was no documentation or an assessment of the resident's right elbow after she returned from the appointment. There was no documentation of what the resident's right arm was placed in. The next documented entry in Nursing Progress Notes was on 7/30/10 and then again on 8/3/10 and there was no documentation of what the resident's right arm was placed in. Interview with the Director of Nursing on 3/25/11 at 8:32 a.m., indicated when the resident visited the orthopedic physician he removed the cast and placed the resident's arm in a sling, however, there was no documentation in the resident's record regarding the sling.		responsible for ensuring ongoing compliance. Compliance date 04/27/11	
SS=D	2. On 3/23/11 at 7:50 a.m., Resident		F514	04/27/2011

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	#6 was observed sitting up in a wheel chair in he room. The resident had a palm protector type splint in place to the left hand. On 3/24/11 at 9:32 a.m., the resident was observed sitting in a wheel chair in her room. The resident had the palm protector in her left hand. MDS (Minimum Data Set) Nurse #2 opened the palm protector that was in the resident's hand. The resident was not able to open the last three fingers of her left hand on her own. The MDS Nurse then performed passive range of motion and was not able to fully open (extend) the three fingers on the resident's left hand. When interviewed at this time, the MDS Nurse indicated the resident had only moderate extension of these fingers at this time. The MDS Nurse also indicated when she completed the 2/16/11 Joint Mobility Assessment she incorrectly at that time. The record for Resident #6 was reviewed on 3/23/11 at 8:04 a.m. The resident's diagnoses included, but were not limited to, syncope, polymyalgia rheumatica, right bundle branch block, high blood pressure, and muscle weakness.		Resident #6 joint mobility assessment was corrected on 03/29/11.Resident #37 no longer requires splints, or slings due to residents refusals. All ortho residents have the potential to be affected by the same deficient practice. All joint mobility assessments will be updated. All residents with splints/casts were audited for placement. Joint mobility assessments will be accurately completed weekly. Splint application will be audited daily M-F by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 by Nursing Administration regarding accurate joint mobility assessments and follow up documentation with fractures. Results of these audits will be presented at monthly PI Committee. Threshold of compliance will be 95% before discontinuing audits. The DON/Designee is responsible for ensuring ongoing compliance. Compliance date 04/27/11	

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	The 3/11 Physician Order Statement indicated there was an order for the resident to wear a left hand splint at all times except during care. The 2/16/11 Joint Mobility Assessment indicated the resident had full extension and range of motion on the fingers on both the right and left hands. When interviewed on 3/28/11 at 8:28 a.m., the Director of Nursing indicated the resident had a contracture to the left hand previously and a splint had been ordered in 2010. The Director of Nursing indicated the documentation on the 2/16/11 Joint Mobility Assessment was inaccurate. 3.1-50(a)(1) 3.1-50(a)(2)			
F9999	STATE FINDINGS In addition to the required inservice hours in subsection(l), staff who have regular contact with residents shall have a minimum if six (6) hours of dementia-specific training within six (6) months of initial employment, or within thirty (30) days for personnel assigned to	F9999	F9999 The Staff Development Coordinator will ensure all staff receives three (3) hours of dementia training annually. Staff has the potential to be affected by the same deficient practice. All associates lacking three (3) hours of dementia training will have one (1) hour of dementia training per month until	04/27/2011

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	the Alzheimer's and dementia special care unit, and three (3) hours annually thereafter to meet the needs or preferences. or both, of cognitively impaired residents to gain understanding of the current standards of care for residents with dementia. This state rule was not met as evidenced by: Based on record review and interview the facility failed to ensure the required three (3) hours of dementia specific training was provided annually for 66 of 81 employees who required annual in-service training. (Employees #1 - #66) Findings include: The facility files for Dementia training of employees were reviewed on 3/28/11 at 8:15 a.m. The following employees did not receive three hours of dementia specific training during 2010. Employee #1, Activities staff hired on 12/9/08 Employee #2, Activities Supervisor hired on 5/21/07 Employee #3, Admissions Coordinator hired on 1/25/01 Employee #4, Social Service Supervisor		all asociates are current. Dementia audits will be conducted weekly by DON/Designee. Staff was in-serviced on 03/28/11, 04/06/11 and 04/12/11 on receiving three (3) hours of dementia training for all staff. Results of these audits will be presented at the monthly PI Committee Meeting for 6 months. Plan to be amended as indicated per monthly review per PI Committee. Threshold compliance will be 95% before discontinuing audits. The DON is responsible for ensuring ongoing compliance. Compliance date 04/27/11.	

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	hired on 9/19/05 Employee #5, Assistant Food Service Supervisor hired on 4/9/01 Employee #6, Assistant Office Manager hired on 2/7/00 Employee #7, Assistant Occupational Therapist hired on 11/28/05 Employee #8, Assistant Speech Therapist hired on 11/20/07 Employee #9, Certified Occupational Therapy Assistant hired on 2/6/03 Employee #10, Certified Occupational Therapy Assistant hired on 2/17/09 Employee #11, Certified Occupational Therapy Assistant hired on 10/11/04 Employee #12, Cook hired on 3/13/00 Employee #13, Cook hired on 9/17/01 Employee #14, Cook hired on 1/11/06 Employee #15, Dietary Aide hired on 11/11/08 Employee #16, Dietary Aide hired on 5/11/06 Employee #17, Dietary Aide hired on 5/15/06 Employee #18, Dietary Aide hired on 10/26/06 Employee #19, Dietary Aide hired on 5/7/08 Employee #20, Food Service Supervisor hired on 3/26/01 Employee #21, Housekeeping Assistant hired on 10/13/01 Employee #22, Housekeeping Assistant hired on 4/13/07			

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	Employee #23, Rehab Services Manager hired on 9/23/02 Employee #24, Laundry Assistant hired on 10/23/03 Employee #25, Licensed Physical Therapy Assistant hired on 6/3/03 Employee #26, Licensed Physical Therapy Assistant hired on 7/29/08 Employee #27, Licensed Physical Therapy Assistant hired on 8/4/09 Employee #28, Licensed Physical Therapy Assistant hired on 6/2/03 Employee #29, LPN hired on 1/28/06 Employee #30, LPN hired on 5/5/09 Employee #31, LPN hired on 10/12/92 Employee #32, LPN hired on 8/2/01 Employee #33, LPN hired on 10/15/03 Employee #34, LPN hired on 11/9/04 Employee #35, LPN hired on 1/17/94 Employee #36, MDS Coordinator hired on 8/6/92 Employee #37, ADON hired on 1/20/04 Employee #38, Nursing Aide hired on 7/17/06 Employee #39, Nursing Aide hired on 9/27/93 Employee #40, Nursing Aide hired on 5/11/04 Employee #41, Nursing Aide hired on 9/30/09 Employee #42, Nursing Aide hired on 3/29/02 Employee #43, Nursing Aide hired on 5/5/09			

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	Employee #44, Nursing Aide hired on 4/30/08 Employee #45, Nursing Aide hired on 6/15/07 Employee #46, Nursing Aide hired on 4/14/09 Employee #47, Nursing Aide hired on 9/4/07 Employee #48, Nursing Aide hired on 8/26/85 Employee #49, Nursing Aide hired on 10/15/05 Employee #50, Nursing Aide hired on 2/19/08 Employee #51, Nursing Aide hired on 11/16/06 Employee #52, Nursing Aide hired on 3/31/09 Employee #53, Nursing Aide hired on 5/22/07 Employee #54, Nursing Aide hired on 7/2/05 Employee #55, Nursing Aide hired on 6/10/08 Employee #56, Officer Manager hired on 3/27/06 Employee #57, Physical Therapy Assistant hired on 5/22/07 Employee #58, Maintenance Staff hired on 11/1/04 Employee #59, Maintenance Supervisor hired on 10/15/01			

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LIFE CARE CENTER OF MICHIGAN CITY	802 US HIGHWAY 20 EAST MICHIGAN CITY, IN46360

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	Employee #60, Receptionist hired on 10/15/07 Employee #61, RN hired on 8/10/07 Employee #62, RN hired on 10/20/06 Employee #63, Registered Occupational Therapist hired on 10/24/07 Employee #64, Registered Physical Therapist hired on 3/3/09 Employee #65, Registered Physical Therapist hired on 11/3/09 Employee #66, Rehab Manager hired on 9/23/02 Interview with the Staff Development Nurse on 3/28/11 at 8:15 a.m. indicated the above employees did not receive the required three hours of dementia training during 2010. 3.1-40(u)			